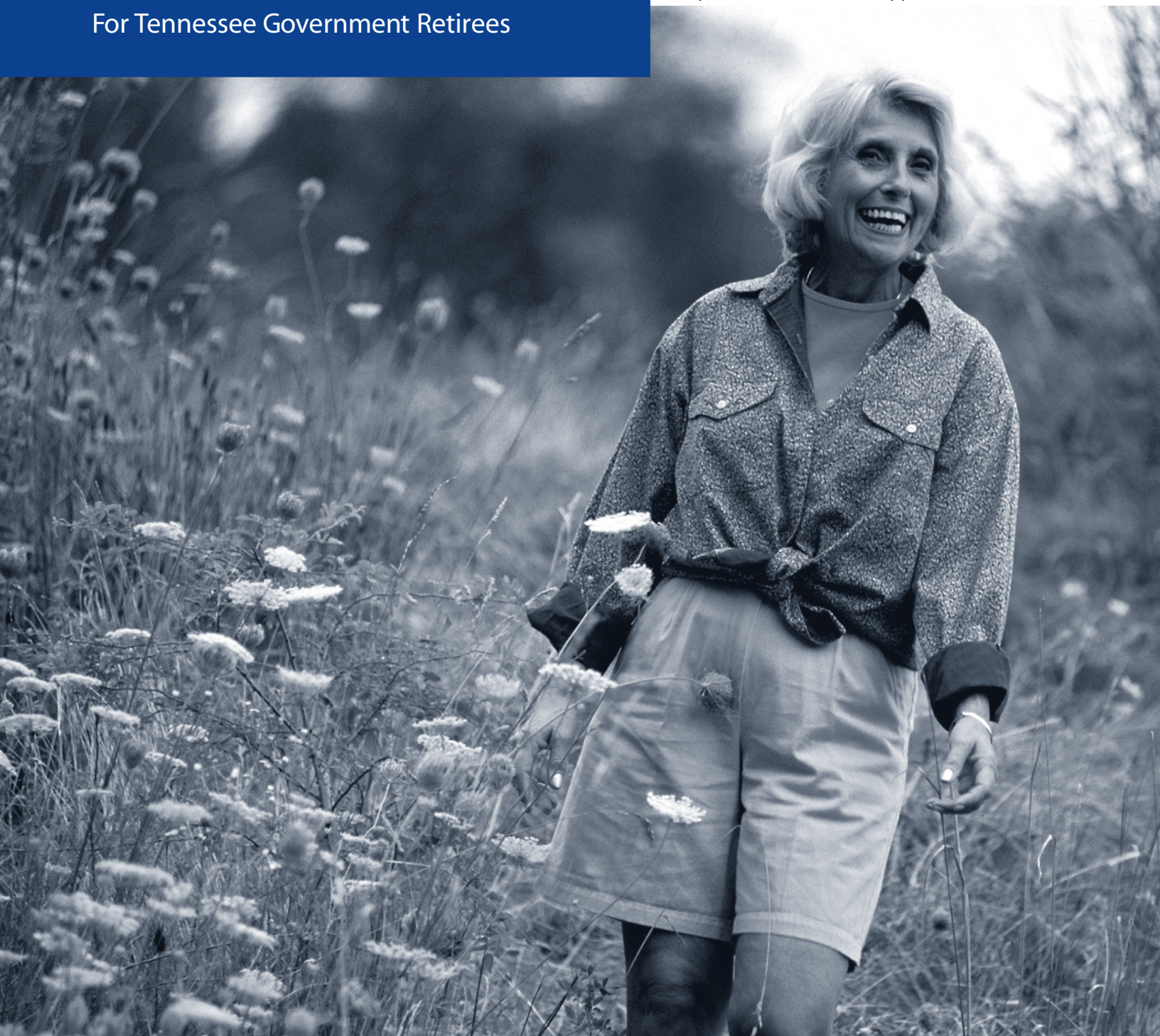
Administered by:

of Tennessee

The Tennessee Plan Handbook

For Tennessee Government Retirees

(Comparable to Medicare Supplement Standard Plan D)



Quick Information

Use this space to record information you will need whenever you seek information about your Tennessee Plan coverage or benefits.

The office to contact about your eligibility status or your premiums is:

_____

The number to call if you have questions about your Tennessee Plan benefits is:

1-800-221-7828
BlueCross BlueShield of Tennessee
801 Pine Street
Chattanooga, TN 37402-2555

The Subscriber number printed on your ID Card is:

_____

The effective (beginning) date of your coverage is:

_____

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Welcome to Your Tennessee Plan Coverage

This handbook contains important details about your Tennessee Plan Medicare supplement coverage. Please review the information and keep this booklet close at hand.

When You Need More Information

If you have questions about your Tennessee Plan benefits, call 1-800-221-7828 toll free, 8 a.m. - 5 p.m. Monday - Friday ET, to speak to a BlueCross BlueShield of Tennessee member service representative.

When You Need to File a Claim

Whenever you receive services from a health care provider, or are admitted to a hospital, be sure to show both cards: your Medicare card and your Tennessee Plan identification card.

1. If the doctor or facility accepts Medicare assignment, their billing office will file your claim for you with Medicare.
2. After paying, Medicare typically will forward payment details to BlueCross BlueShield of Tennessee.
3. With those details, your Tennessee Plan benefits can be paid.
4. Tip: Remind your provider to include your Tennessee Plan ID number on your Medicare claim to avoid any delays or questions.

If A Provider Does Not Accept Medicare

If you receive services from a health care provider or hospital that does not accept Medicare assignment, or if the doctor will not file your Tennessee Plan claims for you, you need to:

1. File your claim first with Medicare.
2. After Medicare pays, send a copy of your Medicare Explanation of Benefits form (or EOB) to the address listed below:
   BlueCross BlueShield of Tennessee
   Claims Service Center
   P.O. Box 180150
   Chattanooga, TN 37401-7150
3. No additional claim form is needed for your Tennessee Plan.

Notice: Subscriber hereby expressly acknowledges his or her individual understanding that this Plan of Coverage is administered by BlueCross BlueShield of Tennessee, Inc., an independent corporation operating under a license from the BlueCross BlueShield Association.

Understanding Your Tennessee Plan Medicare Supplement

It is important that you understand the terms of your Tennessee Supplemental Plan coverage, offered to you by the State of Tennessee and administered by BlueCross BlueShield of Tennessee. Since this is a self-funded plan provided to you by the State of Tennessee, it is not issued or insured by BlueCross BlueShield of Tennessee.

As you read through this handbook, remember that the words "we," "us," and "our" refer to the State of Tennessee, the Plan administrator. The words "you" and "your" indicate you, the Plan Subscriber. And BlueCross BlueShield of Tennessee, as a claims administrator of The Tennessee Plan, will be referred to often by name, or as the "Claims Administrator."

About Your Plan Coverage

The Tennessee Plan coverage provides a program of hospital, skilled nursing facility and medical benefits for individuals who are age 65 or older and enrolled in Medicare. The program is designed to supplement Medicare coverage – that is, to pay certain deductible and coinsurance amounts not covered by Medicare. The plan also covers additional days of care in the hospital, along with other medical services not paid by Medicare.

In return for the payment of monthly premiums by or on your behalf as a Subscriber, the State of Tennessee agrees to the terms and benefits described in this Plan of Coverage.

Right To Return Policy

If you are not satisfied with this Plan, you can cancel it within 30 days after receipt. You will receive a refund of any premiums paid in advance. Any claims paid during this period will be recovered.

This Plan takes effect on the date shown on the information included with your identification card (ID card) packet.

Basic Terms

Here are the basic terms and descriptions that will help you understand your Plan of Coverage.

The Plan

Your Tennessee Plan coverage is sponsored by the State of Tennessee, and claims are administered by BlueCross BlueShield of Tennessee. The coverage is based on the information in this handbook, your signed application, and your ID card.

This Plan provides you certain benefits and responsibilities. These benefits and responsibilities may not be assigned or transferred to any other person.

This Policy is based on the statements you gave on your application. These statements are considered to be representations and not warranties. Only your written statements on the application may be used to defend a claim based on misrepresentation.

Except where required by law, the terms of this handbook cannot be changed unless the State of Tennessee and BlueCross BlueShield of Tennessee agree in writing to the change. Any amendment or endorsement must be signed by the State of Tennessee and made a part of the contract.

The Subscriber

By **Subscriber**, we mean the person who signed the application and in whose name the ID card is issued. The person must be enrolled in Part A of Medicare.

Medicare

Medicare refers to the two programs of health insurance provided under Title XVIII of the Social Security Act. Officially, the two programs are known as Health Insurance for the Aged and Disabled.

The first program, commonly called Part A Medicare, provides basic protection against the costs of inpatient hospital and skilled nursing facility care. For the most part, Part A is financed through the Social Security tax.

The second of the two programs, Part B Medicare, is a voluntary program which covers the cost of physicians' services, outpatient hospital services and certain other services not covered under Part A. It is funded through monthly premiums from participants and contributions from the federal government.

By **Medicare benefits**, we mean the benefits you are eligible for, or would have been eligible for under Part A or B – whether or not you apply for them.

By **Medicare-approved amount**, we mean the amount recognized as reasonable by Medicare for health care expenses of the kinds covered by Medicare. The Medicare-approved amount also includes amounts considered payable under the Medicare Part B fee schedule.

Beginning January 1, 2006 Medicare will offer insurance coverage for prescription drugs through Medicare Prescription Drug Plans and other health plan options. Insurance companies and other private companies work with Medicare to offer these plans.

Providers

Hospital refers to an institution that is qualified as eligible to participate in Medicare as a hospital and meets all of the following requirements:

- Provides inpatient and outpatient services and is compensated by or on behalf of its patients;
- Provides surgical and medical facilities primarily to diagnose, treat and care for the injured and sick;
- Has a staff of physicians licensed to practice medicine; and
- Provides nursing care by registered graduate nurses on duty 24 hours a day.

A **hospital** does not serve, other than incidentally, as a nursing home, a rest home or a place for the aged, for drug addicts or alcoholics.

A **participating hospital** is a hospital which:

- Has an agreement with the Secretary of Health and Human Services of the United States to provide Medicare benefits; or
- Has an agreement with an approved or licensed BlueCross BlueShield Plan to provide hospital services to Plan Subscribers.

A **non-participating hospital** does not have either of these agreements.

A **skilled nursing facility** primarily provides skilled nursing care and related services or rehabilitation services, and has an agreement with the Secretary of Health and Human Services to provide skilled nursing facility services as defined by Medicare.

For identifying covered physician services, the title **physician** includes all of the following:

- Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) legally qualified and licensed without limitation to practice medicine and perform surgery (except interns and residents);
- Doctor of Dental Surgery (D.D.S.);
- Doctor of Dental Medicine (D.M.D.);
- Doctor of Optometry (O.D.);
- Doctor of Podiatric Medicine (D.P.M.); and
- Doctor of Chiropractic (D.C.).

All physicians must practice within the scope of their licenses.

Medicare Definitions

The following terms used in this handbook carry the same meaning as they do in Medicare:

- coinsurance
- deductibles
- inpatient hospital services
- benefit period
- physicians' service
- outpatient hospital services
- outpatient physical or occupational therapy services
- independent laboratory
- skilled nursing facility services
- Medicare fee schedule, and
- medically necessary.

Payment of Premiums for Coverage

The monthly premium for coverage under The Tennessee Plan is established by the State of Tennessee. Regular payment of premiums is required. After the first payment, premiums become due as they are billed.

Grace Period

After the first payment, a deferral period of a full calendar month is allowed. If the premium is not paid within this deferral period, coverage is terminated retroactively to the last month for which premiums were paid. Coverage cannot be reinstated if it was cancelled due to non-payment of premiums.

Change of Rate

The premium charge for coverage under this Plan could change. As required by the State of Tennessee, you will be notified in writing of any rate change at least 30 days before it goes into effect.

Covered Benefits

This section describes the benefits you will receive under The Tennessee Plan. To receive benefits, you must be under a physician's care and the services must be recommended by your physician. These services are subject to the rules of the hospital or other institution, including regulations governing admission.

Services Covered in Part by Medicare

Hospital Inpatient Care. When you are admitted to a participating hospital, benefits will be provided by The Tennessee Plan for the following:

- **inpatient hospital deductible**, the amount of money you pay when admitted to a hospital as an inpatient before you can receive Medicare benefits. The deductible applies once each benefit period as defined by Medicare. The deductible is covered by your Tennessee Plan.
- **coinsurance amount** that applies to inpatient hospital services after the 60th day and before the 91st day. After you have been hospitalized for 60 days, you must share the cost of the hospital care with Medicare. This is called coinsurance and is covered by The Tennessee Plan. Your share of the cost is what The Tennessee Plan covers under this program.
- **coinsurance amount** that applies to inpatient hospital services after the 90th day and before your 60 lifetime reserve days of inpatient care under Medicare expire. This coinsurance is also covered by The Tennessee Plan.

Hospital Outpatient Care. When you are treated in the outpatient department of a participating hospital, benefits are available for the 20% coinsurance amount imposed by Medicare.

Skilled Nursing Services. If you are admitted to a skilled nursing facility, benefits will be provided for the coinsurance amount that applies to skilled nursing services after the 20th day and before the 101st day.

Medical and Other Health Services. Part B Medicare pays 80% of the Medicare-approved amount for Medicare eligible expenses. However, benefits will be provided for the 20% coinsurance amount or remaining amount, whichever is less, for these expenses.

Blood Deductible. The Tennessee Plan will cover the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part A or Part B.

Services Not Covered by Medicare

Additional Days of Hospital Care. After you have used up all of your days of inpatient hospital services under Medicare (including your lifetime reserve days), The Tennessee Plan pays the Diagnostic Related Group (DRG) day outlier per diem rate or other appropriate standard of payment for medically necessary inpatient hospital services, up to a maximum of 365 days per lifetime.

This benefit is paid only if you would have been eligible for Medicare benefits had your days of care not expired.

If you stay in a private room, this Plan pays an amount up to the hospital's most prevalent semi-private room rate.

Worldwide Services. When you receive medically necessary emergency hospital or physicians' services outside of the United States, The Tennessee Plan pays 80% of the billed charges after you pay a $250 deductible, up to a lifetime maximum amount of $50,000, provided:

- The care is received within the first 60 days of a trip outside the United States;
- You are a resident of the United States and are temporarily traveling elsewhere;
- You are legally responsible for payment for the services;
- Benefits are not available under Medicare; and
- The care is needed because of a sudden and unexpected illness or injury.

United States refers to all 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam and American Samoa.

At-Home Recovery. The Tennessee Plan will pay for services to provide short-term, at-home assistance with activities of daily living for those recovering from an illness or injury. The Plan pays up to $40 per visit (each 4-hour segment of service within a 24-hour period will be counted as one visit), up to seven visits a week, and up to a calendar year maximum of $1,600, provided:

- The provider of services is a qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry; and
- Your attending physician certifies the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment, including number of visits, was approved by Medicare; and
- Benefits are provided only during the period you are receiving Medicare-approved home care services or no more than eight weeks after the last service date Medicare approved; and
- The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits.

Benefits will not be provided under this provision if care is received from family members, volunteers or providers other than those described in this section or for visits paid by Medicare or other government programs.

Exclusions

This coverage does not provide benefits for:

- Services and supplies not covered by Medicare, except those specifically included under this Plan;
- Any expense to the extent of any benefits available under Medicare, whether or not you enroll and apply for them; and
- The Medicare Part B yearly deductible amount.

Duplicate Coverage and Coordination of Benefits

Duplicate coverage is health care coverage of a person by two or more programs. Coordination of benefits is simply a way of dividing liability between The Tennessee Plan and coverage provided by insurance companies so that the covered person is able, whenever possible, to meet his or her health care expenses in full - and yet not collect more than the actual costs.

This Plan has been designed by the State of Tennessee to coordinate payments of benefits with other plans to avoid overpayments. This Plan requires that if the Subscriber covered under this group coverage is also covered under any other plan (as defined below), the other plan will be primary and The Tennessee Plan will pay the balance of expenses up to the Medicare allowable charge. In no event will the combined payments exceed 100% of the Medicare allowable charge.

However, The Tennessee Plan is designed to be the primary Medicare supplemental coverage when the Subscriber is not covered under any other Plan (as defined below).

"Plan" means any coverage providing benefits or services for any health care under any other group, franchise or blanket insurance coverage, other health insurance plan, union welfare plan, labor management trusteed plan, governmental plan or any coverage required by statute.

Coordination of benefits prevents duplicate payments and works to the advantage of all members of the group.

Subrogation

Subrogation is another method used to prevent duplicate payments. It works this way:

1. To the extent that The Tennessee Plan provides benefits, you must repay the Plan the amount of such benefits where you receive payment from another person or insurance company for medical expenses.
2. The State of Tennessee assumes your legal rights to the recovery of any payments for medical expenses paid by us because you became ill or were injured by the action or fault of another person. The Plan has the right to recover amounts equal to these payments by suit, settlement or otherwise from the person who caused the illness or injury, his or her insurance company, or other sources such as uninsured motorist coverage.
3. You must give us information and assistance and sign all necessary papers. If this is not done, or if you settle any claim without our written consent, we will be entitled to reasonable and necessary attorney fees and court costs we have in trying to recover payments for medical expenses.

Termination of Coverage

This coverage remains in effect until terminated by the State of Tennessee or by the Subscriber.

Coverage will not be renewed in the event of fraud by the Subscriber or member. Coverage will automatically be canceled if you fail to pay the premium charges within the grace period. The State of Tennessee can decline to renew all Tennessee Plan coverage. This coverage cannot be canceled solely because your health deteriorates.

As the Subscriber, you can cancel the Plan for any reason at the end of the period for which charges have been paid. For whatever reason(s) the Plan is terminated, benefit coverage ends on the next payment due date.

Suspension of Coverage: Medicaid (TennCare) Entitlement

If you become eligible for Medicaid (TennCare), you may notify the State of Tennessee to suspend benefits and charges for coverage under this Plan for the period you are eligible for Medicaid, not to exceed 24 months. Your notice of such suspension must be received by the State of Tennessee within 90 days after determination of your Medicaid eligibility.

Upon receipt of timely notice to suspend coverage under this Plan, the State of Tennessee will return that portion of charges that correspond to the period of Medicaid eligibility, less the amount of any claims administered.

Coverage under The Tennessee Plan may be reinstated on the date you lose entitlement to Medicaid if such loss occurs within 24 months after suspension. You must provide notice of loss of Medicaid entitlement within 90 days after the date of such loss and pay charges for the period for which coverage is reinstated.

Coverage Changes

The terms of this coverage or the benefits may change. You will be notified in writing of any changes that occur. Your continued payment of the charges indicates acceptance of the change.

Benefits under this coverage will automatically be adjusted to conform to applicable changes in the Medicare deductible amounts and coinsurance percentages. Any such notice will be mailed to you at the address last shown in the records maintained by the State of Tennessee.

Claims & Appeals

If you have a claim for benefits, BlueCross BlueShield of Tennessee must receive written notice at the main office in Chattanooga. When you are admitted to a hospital or skilled nursing facility, present your ID Card at the admission desk and the hospital or facility personnel will notify BlueCross BlueShield of Tennessee.

In order to process your claims, BlueCross BlueShield of Tennessee may need information from the person or organization that supplied the service. As a Subscriber accepting this Plan, you agree to authorize the physician, hospital or other provider to release any necessary information and records to BlueCross BlueShield of Tennessee.

Generally, the benefits will be provided as directed by you. However, BlueCross BlueShield of Tennessee has the right to pay you directly for all benefits administered under this Plan.

Claims must be filed within 13 months from the date of service to be eligible for reimbursement. BlueCross BlueShield of Tennessee will not process a claim received after the above applicable timely filing period.

Appeal Procedures

If you experience a problem relating to the plan policies or the services provided, there are established procedures to help you resolve your complaint. These procedures do not apply to any complaint or grievance alleging possible professional liability, commonly known as malpractice, or for any complaint or grievance concerning benefits provided by any other plan.

Administrative Appeal

To file an appeal regarding an administrative process or decision (such as transferring between health plans, effective dates of coverage issues, or timely filing issues) contact the Tennessee Consolidated Retirement System immediately.

Appealing to the Claims Administrator

If you are in disagreement with a decision or the way a claim has been paid or processed, you or your authorized representative should first call member services at BlueCross BlueShield of Tennessee at 1-800-221-7828 to discuss the issue. If the issue cannot be resolved through member services, you may file a formal request for review or member grievance by completing the appropriate form and returning it within the specified time frame. When your completed form is received, you will get an acknowledgement letter advising you what to expect regarding the processing of your grievance. When a determination is made, you will be notified in writing and advised of any further appeal options.

Appealing to the Plan Administrator

The State of Tennessee, Division of Insurance Administration has an appeal process that is available to you AFTER you have exhausted the grievance process with the claims administrator. Appeals must be requested in writing within two years of the claim determination or decision. To file an appeal at the state level, the member should send a letter and supporting documentation (such as explanation of benefit statements, decision letters, statements from health care providers, and medical records) to:

Appeals Coordinator, Division of Insurance Administration
13th Floor, Wm. R. Snodgrass Tennessee Tower
312 Eighth Avenue North
Nashville, TN 37243

It is a good idea to maintain a copy of all correspondence you send. Specific questions regarding the appeal process may be directed to the appeals coordinator at 615-741-3590 or 1-800-253-9981.

The appeals coordinator in the Division of Insurance Administration will thoroughly review all information submitted to determine the exact nature of the appeal. The majority of requests for appeal require additional review by the claims administrator. The average review takes approximately 60 days to complete. Some cases may require additional time for review depending on individual circumstances. Some cases may also require review by the state's independent medical consultant. If consideration of your appeal does not result in a satisfactory resolution, the appeals

coordinator may schedule it for additional review by the Insurance Appeals Staff Review Committee. When this occurs, the member will have the option of attending the committee meeting, or the appeal can be reviewed based on the written record. The Staff Review Committee will hear the appeal and their recommendation will be reported to the Appeals Subcommittee. The subcommittee will respond to the appeals coordinator within two weeks to indicate whether they agree with the Staff Review Committee's recommendation or vote to review the appeal at a second meeting. If the subcommittee agrees with the recommendation of the Staff Review Committee, the decision will stand. Members will be notified in writing as to whether or not requests are approved or denied by the committee. For denial decisions, the notification letter will explain any additional appeal options.

BlueAccess

Tennessee Plan members can use BlueAccess, the secure area of the BlueCross BlueShield of Tennessee Web site, bcbst.com, to view plan information in a secure environment using member self-service with a user ID and password. With your BlueAccess ID and password, you can:

- Verify benefits, including eligibility and coverage details
- Check medical claim status (except prescription drug claims)
- Look up prior authorization status
- View and print an online Explanation of Benefits form (EOB)
- Update your Coordination of Benefits information (COB) if you have other insurance coverage
- Order ID cards

Women's Health and Cancer Rights Act

Your medical plan's coverage of a medically necessary mastectomy also includes post-mastectomy coverage for reconstruction of the breast, surgery on the other breast to achieve the appearance of symmetry, prostheses, and physical complications during any state of the mastectomy, including lymphedemas. This coverage will be provided in consultation with the attending physician and patient. Benefits are subject to the same annual deductibles and coinsurance as other services and pre-existing waiting periods apply, if applicable.

Confidentiality and Privacy

Your health is your own private business. Your medical records and claims payment history will be treated in a confidential manner. When you enroll in the plan, you give routine consent for certain matters. That allows the company to release information without your prior written consent for these purposes:

- Claims processing
- Performing peer review, utilization review, and medical audits
- Administration of programs established by us for quality health care and control of health care costs
- Medical research and education.

Important steps are taken to protect your privacy:

- Employees have been trained to understand the importance of safeguarding your privacy. In fact, they sign confidentiality agreements to ensure they will carry out the established policies.
- Contracted practitioners and providers follow confidentiality guidelines set forth by the state in which they practice.
- Vendors must sign confidentiality agreements if they receive personal health information for purposes of plan administration such as measurement of data to improve quality.
- It is the policy not to release member-specific health information to employers unless allowed by law.
- Members have the right to approve the release of personal health information in special circumstances beyond those listed above.

You are encouraged to call one of the member service representatives if you have questions about privacy policies and practices.

Need benefits information?

Go to www.bcbst.com and click on

BlueAccess

Your information. Anytime you need it.

BlueCross BlueShield of Tennessee

801 Pine Street
Chattanooga, TN 37402

www.bcbst.com

ST-MED-01 (11/2005)